REQUEST FOR WITHDRAWAL OF APPEAL

Michigan Department of Community Health

*The purpose of this form is for an appellant / beneficiary to **withdraw** his / her request for an appeal (either an Administrative Hearing or a Department Review).*

APPELLANT INSTRUCTIONS:

- Answer ALL questions completely.
- Please use a PEN and PRINT FIRMLY.
- Remove the BOTTOM copy for your records.
- If you have any questions, you may call toll free:

  1 (877) 833 - 0870.

- After you complete this form, mail it in the enclosed postage paid envelope to:

  ADMINISTRATIVE TRIBUNAL and APPEALS DIVISION
  MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
  PO BOX 30763
  LANSING MI 48909

Name			Telephone Number ( )	Case Number	
Your Address (No. & Street, Apt. No., etc.)			Signature		Date Signed
City	State	ZIP Code			
Docket Number.	Date of Scheduled Hearing / Review			Your Social Security Number	

Please CANCEL my request for an appeal for the following reason:

☐ The Department of Community Health has changed its action / decision.

☐ Other (Please explain):

Authority: 42 CFR 431.200 – 431.250; 42 USC 1397aa; 42 USC 700 et seq.; MCLA 330.1001 et seq.; MCLA 400.1 et seq.; MCLA 333.1101 et seq.; Department of Community Health Appropriations Act.

Completion: Is voluntary.

The Department of Community Health is an equal opportunity employer, services, and programs provider.

If you do not understand this, call the Department of Community Health.
Si Ud. no entiende esto, llame a la oficina del Departamento de Salud Comunitaria.
إذا لم تفهم هذا، اتصل بإدارة الصحة المحلية التابعة لو لاية مينتشيجن.

1 (877) 833 - 0870

COPY DISTRIBUTION: WHITE - Administrative Tribunal
YELLOW - Person requesting a withdrawal